UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SIMPONI (golimumab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext.and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete, and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY AND THE COMPLETED FORM TO: 801-536-0477

CRITERIA:

Rheumatoid Arthritis or Psoriatic Arthritis

- Age requirement: 18 years and older
- Diagnosis of moderate to severe Rheumatoid Arthritis, Psoriatic Arthritis
- History of treatment, incomplete response or intolerance to Methotrexate, or one other DMARD or second line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquine, etc.)
- The number of swollen joints, must be 6 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- The number of tender joints must be 9 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- Simponi may not be given with other biologic agents such as Interferon, experimental medications or combination.

Ankylosing Spondylitis

- Diagnosis of Ankylosing Spondylitis
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Negative TB skin test or history of treatment for latent TB infection.
- Rheumatology consultation within the last 60 days.
- Simponi may not be given with other biologic agents such as Interferon, experimental medications, or combinations.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.